

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445222	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER SOUTHERN TENN MEDICAL CENTER SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 629 HOSPITAL ROAD WINCHESTER, TN 37398	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

K 062 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by:
Based on observations, the facility failed to maintain the sprinkler system.

The finding included:

Observation on 4/13/2015 at 10:10 a.m., revealed the sprinklers were loaded with foreign material in the following locations:

- The Administrator room (2 out of 3 sprinklers).
- Near the shower room (in hallway).
- Room 134, 131 and 139 (2 out of 3 sprinklers).
- Room 141, 143, 142 (1 out of 3 sprinklers).
- Wash room in the kitchen (3 out of 4 sprinklers).

National Fire Protection Association (NFPA) 25, 2.2.1.1, 1998 Edition.

This finding was verified by the maintenance director and acknowledge by the administrator during the exit conference on 4/13/2015.

K 062 **Corrective action:** The sprinklers in the Administrator's office, near the shower room in the hallway, and rooms 131, 134, 139, 141, 142, and 143 were cleaned by Plant Operations staff by 5/5/15. **Identification of other residents potentially affected:** Because all residents have the potential to be affected by foreign material on sprinkler heads, the following actions are taken: **Action:** Plant Operations staff and Environmental Staff will perform an inspection of all sprinkler heads to assess for corrosion/cleaning needs by 5/6/15. By 5/6/15, the sprinkler head assessment schedule (Attachment E) has been updated by the Plant Operations and Environmental Services Managers from yearly to every six months. **Audits:** Plant Operations Manager/Environmental Services Manager/Designee will monitor the results of the sprinkler head assessment and cleaning plan on a weekly basis for 6 months and then monthly for 3 months (Attachment F). Any negative findings will be addressed immediately and the results of the audits will be reported to the PI committee monthly beginning May 2015 for review and correction of any noncompliance. This committee is comprised of the Administrator, Director of Nursing, Social Worker, Dietitian, LPN, RN Charge Nurse and Rehab representative. The PI Committee will make recommendations and develop a plan of correction if noncompliance is noted. Audit results will also be reported quarterly to Quality Council beginning 6/18/15. Members of this committee include Chief of Staff, Chief of Medicine, Chief of Surgery, Chief Executive Officer, Chief Nursing Officer, Quality Management Director, Risk Manager, Licensed Nursing Home Administrator and the Director of Resource Management.

5/5/15

5/6/15

5/30/15

6/18/15

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445222	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - EMERALD/HODGSON B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER SOUTHERN TENN MEDICAL CENTER SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 629 HOSPITAL ROAD WINCHESTER, TN 37398		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K9999	FINAL OBSERVATIONS During the annual survey completed on 4/13/2015, the facility was found to be in compliance with the requirements of the National Fire Protection Association (NFPA) 101, Life Safety Code, 2000 Edition, Chapter 19, Existing Health Care Occupancies.	K9999		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James Edwards</i>		TITLE <i>Administrator</i>		(X6) DATE <i>5/12/15</i>

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.